Admission and Discharge Protocols For Persons with Mental Retardation Served in State Mental Retardation Facilities

The attached protocols are designed to provide consistent direction and coordination of those activities required of state facilities and Community Services Boards in the development and implementation of discharge planning. The activities delineated in these protocols are based on or referenced in either the Code of Virginia or the Community Services Performance Contract. ***In these protocols, the term Community Services Board (CSB) includes local government departments with policy-advisory CSBs, established pursuant to 37.1-195 of the Code of Virginia, and behavioral health authorities, established pursuant to 37.1- 242 of the Code of Virginia.***

DEFINITIONS

The following words and terms, when used in these protocols, shall have the following meanings, unless the context clearly indicates otherwise.

"Case management community services board (CSB)" means a citizen board established pursuant to 37.1-195 of the *Code of Virginia* that serves the area in which an adult resides or in which a minor's parent, guardian or legally authorized representative resides. The case management CSB is responsible for case management, liaison with the facility when an individual is admitted to a facility, and predischarge planning. If an individual, the parents of a minor receiving service, or legally authorized representative chooses to reside in a different locality after discharge from the facility, the community services board serving that locality becomes the case management CSB and works with the original case management CSB, the individual receiving services, and the state facility to effect a smooth transition and discharge. Reference in these protocols to CSB means case management CSB, unless the context clearly indicates otherwise.

"Choice" means, as applied to Medicaid covered ICFs/MR programs, that individuals are provided opportunities to select providers and are encouraged and taught to make choices, and to exercise control over themselves and their environments.

"Commissioner" means the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services.

"Discharge plan" or predischarge plan (hereafter referred to as the discharge plan) means an individualized plan for post facility services that is developed by the case management CSB in accordance with § 37.1-197.1 of the *Code of Virginia* in consultation with the state facility interdisciplinary team. This plan describes the community services and supports needed by the individual being served following an episode of care in a state facility and identifies the providers of such services and supports. The discharge plan is required by § 37.1-197.1 and § 37.1-98 of the *Code of Virginia*. A completed, finalized, or final discharge plan means the *Discharge Plan Form (DMH 885E 1194 or DMH 885E 1194B)* on which all of the services to be received upon discharge are shown, the providers that have agreed to provide those services are identified, the frequency of those services is noted, and a specific date of discharge is entered.

"Facility" means a state training center for individuals with mental retardation under the supervision and management of the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services.

"Interdisciplinary Team (IDT)" is composed of those individuals (professionals, paraprofessionals and non-professionals) who possess the knowledge, skills and expertise necessary to accurately identify the comprehensive array of the individual's needs and design a program that is responsive to those needs.

"Legally authorized representative" means a person permitted by law or regulations to give informed consent for disclosure of information and give informed consent to treatment on behalf of an individual who lacks the mental capacity to make such decisions.

"Mental retardation" means the substantial subaverage general intellectual functioning that originates during the developmental period and is associated with impairment in adaptive behavior.

I. Admission to State Facilities

	Facility Responsibilities	CSB Responsibilities
1.1		Section 37.1-197.1 of the *Code of Virginia* requires Community Services Boards (CSBs) to provide prescreening services. Section 37.1-65.1 requires a prescreening report from a CSB as part of the judicial certification of eligibility for admission process. Accordingly, it is the responsibility of CSBs to perform a face-to-face pre-admission screening that confirms the appropriateness of the individual's admission to a state facility.
1.2		If the individual is not able to make the necessary decisions regarding treatment, habilitation, and admission to a state facility, and there are no family members available, CSB staff shall arrange for a legally authorized representative, if one is available to admit the individual to the training center, if one has not been arranged already. If one is not available, judicial certification is sufficient.
1.3		The case management CSB, after review of all pertinent information and consideration of all the options, and if the individual or family member or legally authorized representative has made the documented choice of an ICF/MR placement, shall complete an application packet for regular admission to a training center. The completed application packet shall be forwarded to the training center serving the area in which the individual, family member or legally authorized representative resides.
1.4	Within 30 working days of receipt of the completed application packet for regular admission, the facility director shall notify the case management CSB in writing of the individual's eligibility for admission.	The case management CSB shall advise the individual, family member, or legally authorized representative of the facility's decision. If the individual is determined to be eligible for admission, the case management CSB shall initiate a judicial proceeding to certify the individual's eligibility for admission pursuant to 37-65.1 of the *Code of Virginia*.
1.5	Upon receipt of judicial certification, a date for admission into the facility shall be set by the facility director and forwarded to the case management CSB.	If the individual is determined not suitable for admission, the case management CSB may request reconsideration of that decision (12 VAC 35-200-10) within 10 working days of receipt of that decision. The case management CSB may request reconsideration of that decision by submitting a request in writing to the commissioner within 10 days of receiving that determination.
1.6	Upon admission, if the resident is *not* able to make the necessary decisions regarding treatment and habilitation and there are no family members available, state facility staff shall arrange for substitute consent as appropriate.	

II. Needs Assessments & Discharge Planning

	Facility Responsibilities	CSB Responsibilities
2.1	The state facility interdisciplinary team (IDT) shall assess each individual upon admission and periodically thereafter to determine whether the state facility is an appropriate placement.	
2.2	On admission, a comprehensive needs assessment shall be performed. A nursing assessment shall be completed at admission. The facility physician shall complete a comprehensive physical examination. The physician will order routine laboratory studies, and the blood for the studies will be drawn within 24-hours following admission. Where it is impossible to both order the studies and draw blood for the studies within this 24-hour period, both shall be completed by the first business day following admission. However, if medically indicated, the studies shall be ordered and blood drawn immediately. Within thirty (30) days of admission the following assessments shall be completed: vocational, recreational, residential, psychological, pharmaceutical, nutritional, dental, physical therapy, occupational therapy, and speech. The facility shall complete the MAP19 and MAP 121A for initiation of Medicaid payment and submit them to the facility's reimbursement department.	CSB staff shall initiate discharge planning upon the individual's admission to a state facility. Discharge planning begins at the initial IDT meeting and continues on the *Discharge Plan (DMH 885E 1194)* form. In completing the *Discharge Plan*, the CSB shall consult with members of the IDT, the individual receiving services or his legally authorized representative, and with his consent, other parties. The *Discharge Plan* shall be developed in accordance with the *Code of Virginia* and the community services performance contract and shall: • include the anticipated date of discharge from the state facility; • identify the services and supports needed for successful community placement; and • • specify the public and private providers that have agreed to provide these services, consistent with choice principles.
2.3	The initial IDT meeting shall occur within 30 days of admission of the individual to the facility. The facility shall, to the greatest extent possible, accommodate the CSB when scheduling IDT meetings. The facility shall inform the case management CSB of the date and time of the initial IDT meeting at least five days prior to the scheduled meeting.	CSB staff shall make arrangements to attend or otherwise participate in the initial IDT meeting. If the CSB staff is unable to physically attend the IDT meeting, the CSB shall notify the facility social worker for the IDT. If the CSB is unable to participate in the initial IDT meeting, the CSB staff shall contact the IDT facility social worker to discuss case specifics prior to the IDT meeting
2.4	The state facility, in collaboration with CSB staff, shall arrange for telephone and video conferencing accommodations for CSB staff and for legally authorized representatives and family members who are invited to attend meetings but are unable to attend in person.	

Facility Responsibilities	CSB Responsibilities

2.5	The *Needs Upon Discharge (DHM 885E 1194)* form shall be initiated at the first IDT meeting and updated at subsequent IDT meetings. If the CSB staff is unable to participate in the initial IDT meeting, the facility social worker shall send a completed *Needs Upon Discharge* form to the CSB within one (1) working day of the IDT meeting with a request that this information be used in the CSB's development of the *Discharge Plan*.	At the first IDT meeting, the CSB shall fill out as completely as possible the *Discharge Plan* section of the form, based on information in the *Needs Upon Discharge* form. If the CSB *is* unable to participate in the initial IDT meeting, the CSB shall fill out as completely as possible the *Discharge Plan (DMH 885E 1194B)* using the *Needs Upon Discharge* information sent by the facility. The CSB shall return this completed *Discharge Plan* to the facility IDT social worker within t*hree working* days of the IDT meeting or receipt of the *Needs Upon Discharge* form and other IDT information.
2.6		The CSB shall not complete the *Discharge Plan* in the absence of the *Needs Upon Discharge* form. If the *Needs Upon Discharge* form is not available at the initial IDT meeting or within three working days following the meeting: • CSB staff shall notify the IDT leader and facility social worker. • • If the *Needs Upon Discharge* form is not made available upon notification of the problem, CSB staff shall notify the CSB Mental Retardation Director or his designee, who shall notify the Facility Social Work Director of the problem. • • If the facility does not correct the problem, the CSB Executive Director shall contact the Facility Director in writing within two working days of notification by the Mental Retardation Director or his designee. • • If the facility still does not correct the problem, the CSB Executive Director shall notify the Assistant Commissioner for Facility Management in writing of the problem and include supporting documentation
2.7	As an individual's needs change, the facility social worker shall document changes on the *Needs Upon Discharge (DMH 885E 1194)* section of the form and in the individual's case record.	As the individual's needs change, the *Discharge Plan* shall be updated at subsequent meetings. If the individual's needs change, the CSB staff shall update the *Discharge Plan* to address changes to the *Needs Upon Discharge* form.

	Facility Responsibilities	CSB Responsibilities
2.8	In the event that a CSB fails to return the completed *Discharge Plan* form to the facility IDT social worker within three days of the initial IDT meeting or upon receipt of the *Needs Upon Discharge* form and other IDT information: • The IDT leader or designee shall notify the Director of Social Work and the Facility Director in writing of the problems and issues associated with the development or completion of the *Discharge Plan*. • If the CSB fails to return the *Discharge Plan* form upon notification of the problem, the Facility Social Work Director shall notify the CSB Mental Retardation Director or his designee of the problem and document the contact in the individual's record. • If the CSB does not correct the problem, the Facility Director shall contact the CSB Executive Director in writing within two working days of notification by the IDT to request a meeting with the Executive Director and Mental Retardation Director or his designee in an effort to resolve the problems and issues associated with the development or completion of the *Discharge Plan*. • If the CSB has not corrected the problem, the Facility Director shall notify the Assistant Commissioner of Facility Management and the Assistant Commissioner of Administrative and Regulatory Compliance in writing and include supporting documentation.	• .

III. Individualized Treatment Planning

	Facility Responsibilities	CSB Responsibilities
3.1	The Interdisciplinary Team (IDT), in consultation with CSB staff, shall, within 30 days of admission, develop the individualized habilitation plan that will determine the care and services to be provided to the resident by the facility. The state facility, in conjunction with the CSB, shall arrange for telephone or video conferencing accommodations for CSB staff, legally authorized representatives, and family members who are unable to attend IDT meetings in person. Following the IDT meeting, using information gathered during the development of the habilitation plan, CSB staff, in consultation with the facility social worker, shall begin development of the *Discharge Plan*.	
3.2	The individualized habilitation plan and *Discharge Plan* shall include input of the resident, and his legally authorized representative (or family member if there is no legally authorized representative). The resident and legally authorized representative (or family member if there is no legally authorized representative) shall be included in the IDT meetings and shall be requested to sign the individualized habilitation plan and the *Discharge Plan* that have been developed.	
3.3	The IDT shall ascertain, document, and address the preferences and wishes of the resident and legally authorized representative (or family member if there is no legally authorized representative) as to the services and supports outlined in the individualized habilitation plan and *Discharge Plan*, including the individual's placement upon discharge.	
3.4	The behaviors and skills that a resident will need to be successful in the community shall be considered during the development of the individualized habilitation plan. The services and supports identified in the habilitation planning process will affect the development of the resident's *Discharge Plan.*	
3.5	The facility shall notify the resident and legally authorized representative (or family member if there is no legally authorized representative) and CSB staff at least 30 days prior to any IDT meeting by letter of the location and time of the meeting. The facility shall, to the greatest extent possible, accommodate the CSB and the resident or legally authorized representative (or family member if there is no legally authorized representative) when scheduling IDT meetings.	
3.6	The IDT shall review regularly the progress of the resident and make necessary changes to the resident's individualized habilitation plan and *Needs Upon Discharge* form. These reviews shall be conducted at 60, 90, and 180 days following admission to the facility and annually thereafter. These reviews shall include a discussion of the resident's and legally authorized representative's (or family member if there is no legally authorized representative) choices regarding where services are received.	The CSB shall participate in these reviews if the resident's status changes and in annual reviews. The CSB shall update the *Discharge Plan* to address any status changes identified during these reviews. *RECOMMENDED PRACTICE:* CSBs should participate in all reviews

Facility Responsibilities		CSB Responsibilities
3.7	Following any IDT meeting, the facility social worker shall document any changes in the resident's status that affect the *Discharge Plan* and shall ensure that the CSB case manager is informed of those changes.	The case management CSB shall update the *Discharge Plan* to ensure that the services outlined are consistent with the needs of the resident.

IV. Preparing for Discharge

Facility Responsibilities	CSB Responsibilities
4.1	Preparing the resident for discharge is an ongoing process in which his changing support needs are analyzed and choices of the provider (e.g., state facility, community ICF/MR, or public or private Waiver program) are reviewed annually by the IDT in consultation with the resident, legally authorized representative, (or family member, if there is no legally authorized representative), and case management CSB
4.2	The facility should consider the factors listed below when determining if a resident is ready for discharge. • A resident is medically stable. The resident is not undergoing any significant changes with regard to physical or mental condition. • The resident's general skill acquisition enables him to function successfully in his daily routine with minimum supervision or assistance. • For individuals with the dual diagnosis of MR/MI, an individualized behavior management or a crisis plan must be included in the Discharge Plan. These plans must work in conjunction with any pre-existing MR/MI protocols developed between the facility and the service area it serves. *RECOMMENDED PRACTICE:* Residents who have a dual diagnosis and who routinely receive psychotropic medications should not require PRN medication. Following successful medication adjustments, a resident's mental status should remain stable for 6-months
4.3	When the individual receiving services and his legally authorized representative (or family member, if there is no.legally authorized representative) choose to consider a community provider as opposed to continued treatment in the state facility, the IDT, in consultation with the resident, legally authorized representative (or family member if there is no legally authorized representative) and case management CSB, shall review the resident's status in conjunction with the factors listed below to determine if the resident's name should be placed on the Ready for Discharge List. • the resident is able to function with consistent and appropriate support • the resident is usually able to apply skills learned in training situations to other settings and environments • is generally able to take care of most personal care needs (even if with assistance), make known to others his basic needs and wants, and understands simple commands • is generally able to conduct himself appropriately (with supports as needed) when allowed to have time away from the facility's premises • does not require extensive medical or behavioral interventions to ensure progress in community programs. Residents who meet at least three of these criteria, in consultation with their IDT team, may have his name placed on the Discharge Ready List if the LAR (or family member if there is no legally authorized representative) or resident chooses to consider a community provider instead of continued placement in a state facility
4.4	When the resident or legally authorized representative (or family member if there is no legally authorized representative) chooses for the resident to be discharged from the facility, the IDT shall complete the *Needs for Discharge* form and the case management CSB shall complete the final *Discharge Plan*.

	Facility Responsibilities	CSB Responsibilities
4.5	Decisions regarding discharge shall be made at IDT meetings in consultation with the resident or his legally authorized representative, (or family member if there is no legally authorized representative) and case management CSB. Once the IDT determines that the resident will be discharged, the IDT shall notify the Facility Director and CSB Members of the IDT will assist the case management CSB staff as appropriate, to finalize the *Discharge Plan,* pursuant to 37.1-197.1 of the *Code of Virginia*.	The case management shall complete the final *Discharge Plan* that is required by §37.1-197.1. of the *Code of Virginia*. The final *Discharge Plan* shall be completed within 30 days of notification by the IDT facility social worker. The CSB shall be present at least one IDT meeting within 45 calendar days prior to discharge. The case management CSB shall implement the final *Discharge Plan* within 90 days. If the *Discharge Plan* cannot be implemented within 90 days, the CSB shall complete the *Community Choice Waiting List. (aka Extraordinary Barriers)*
4.6		After discharge, if the individual is not able to make the necessary decisions regarding treatment, and habilitation and there is no legally authorized representative or family member (s) available, CSB staff shall arrange substitute consent as appropriate. *RECOMMENDED PRACTICE:* Whenever possible, a substitute decision maker should be in place by the individual's date of discharge, if it is determined that the habilitation and medical needs of the consumer can be met in the community only with a substitute decision-maker.
4.7	When there is a disagreement regarding the appropriateness or availability of community supports and this affects the completion of the Discharge Plan, the CSB and state facility are expected to make a reasonable effort to resolve the disagreement before sending a written request for resolution to the DMHMRSAS. This effort is to include at least one face-to-face meeting with facility and CSB staff at a level higher than the IDT Team. Written documentation of the contents meeting shall be included in the individual client's record. In the event that a resolution is not forthcoming, the party disagreeing with the individual's readiness for discharge is responsible for initiating a request in writing to DMHMRSAS under the conditions specified in Attachment 5.3.4 of the Community Services Performance Contract.	

V. Completing the Discharge Process

	Facility Responsibilities	CSB Responsibilities
5.1	At time of discharge, the IDT facility social worker shall compile a discharge packet that will include: • Final discharge summary, which includes date of discharge, appropriate services and supports and identifies service providers and case manager. • Medical history and current medical information signed by the facility physician. Also, within 30 days of actual discharge, the facility physician will include a statement indicating that the individual is free of communicable diseases.	The CSB shall assure that the individual has received information about and has visited the sites of the community providers that are available, consistent with consumer choice. A signed copy of the Virginia Home and Community Based Waiver Choice of Providers (DMH 885E 1148) shall be placed in the individual's discharge packet.
5.2	Thirty days before discharge, the facility staff, in collaboration with CSB staff, shall initiate applications for Medicaid, Medicare, Social Security SSI, and other final entitlements. Applications shall be initiated in a timely manner prior to discharge.	The CSB shall be responsible for accessing any financial assistance and benefits for which the individual will be eligible after discharge and for identifying a representative payee, if necessary.
5.3	To facilitate follow-up, the facility social worker shall notify the CSB of the type of entitlement application and the date on which it has been submitted. The facility social worker shall notify the Social Security Administration of the individual's change of address to facilitate the transfer of the individual's financial benefits, including SSDI/SSI. The facility social worker shall notify the DMHMRSAS Reimbursement Office of the individual's *Discharge Plan* and date.	
5.4	The facility social worker shall document in the individual's case record that the case management CSB has been notified of the individual's condition and has agreed to accept the individual for service.	

VI. Transfer of CSB Case Management Responsibility for Discharge Planning

	Facility Responsibilities	CSB Responsibilities
6.1	A transfer of case management responsibility shall be initiated when the individual receiving services or his legally authorized representative (or family member if there is no legally authorized representative) decides to relocate to another CSB service area.	
6.2	If this decision to transfer CSB case management responsibility is expressed to the facility, the facility social worker shall indicate this intention in the individual's case record and the reason(s) for doing so. Prior to any further discussion with the individual or his legally authorized representative (or family member if there is no legally authorized representative), the facility staff shall contact the current case management CSB and the CSB in whose area the individual or his legally authorized representative (or his family member if there is no legally authorized representative) has decided to relocate.	If this decision to transfer CSB case management responsibility is expressed to the current case management CSB, the CSB shall indicate this intention in the individual's case record and the reason(s) for doing so. The CSB shall contact the state facility and the CSB in whose area the individual or his legally authorized representative (or his family member, if there is no legally authorized representative) has decided to relocate. Upon notification, the two CSBs shall begin discussion regarding the *Discharge Plan* and the new case management CSB's participation in future IDT meetings.
6.3		The current case management CSB shall provide information to the prospective case management CSB about the individual's *Discharge Plan*.
6.4		Both the current and the prospective case management CSBs shall meet, preferably before the next scheduled IDT meeting, to develop a case management transition plan, which shall specify the date on which case management responsibility shall transfer.
6.5		The current case management CSB shall provide case management for the consumer until the transition is complete.
6.6		If the two CSBs cannot agree on a transition plan before the individual is discharged, they shall seek resolution from the Assistant Commissioner for Facility Management and the Assistance Commissioner for Administrative and Regulatory Compliance.